



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

BASIC LIFE INSURANCE BENEFICIARY DESIGNATION APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration

26th Floor, William R. Snodgrass TN Tower • Nashville, Tennessee 37243 • 615.741.3590 or 1.800.253.9981 • Fax: 615.741.8196

TYPE OF REQUEST

- ☐ New Enrollment
☐ Beneficiary Change

This form is to be used by individuals who elect **NOT** to enroll in health insurance offered by the State Group Insurance Program. Participants will be provided with \$20,000 of basic term life coverage and \$40,000 of basic special accident coverage with the premium being provided by the State of Tennessee. This form must be completed and returned to your agency benefits coordinator to process your enrollment and designate your beneficiary.

EMPLOYEE INFORMATION

Name	Social Security Number	Date of Birth	
Employing Department/Agency	Budget Code	Date of Hire	
Work Address	City	State	Zip Code
Home Address	City	State	Zip Code
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Daytime Phone Number	

PRIMARY BENEFICIARY

Name	Social Security Number	Relationship	
Home Address	City	State	Zip Code

SECONDARY BENEFICIARY

Name	Social Security Number	Relationship	
Home Address	City	State	Zip Code

AUTHORIZATION

I understand that this enrollment is NOT for health insurance coverage and is for basic term life and basic special accident coverage only. Coverage is provided to employees only (not spouse or child). I further understand that a new form must be completed and returned to my agency benefits coordinator any time I want to designate a new beneficiary. Failure to designate a beneficiary will result in the proceeds being paid to my estate in the event of my death.

Upon termination of employment, I may continue this coverage on a direct pay basis to the insurance company; however, payment of monthly premiums is my responsibility.

Employee Signature_____
Date